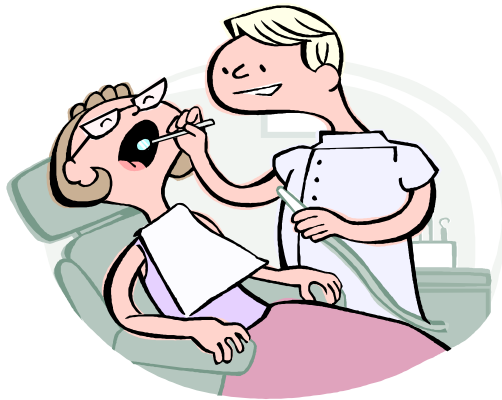


Missouri Medicaid Dental Billing Book



Missouri Department of Social Services
Division of Medical Services

Created by the Provider Education Unit

Preface

This Dental training booklet contains information to help you submit claims correctly. The information is only recommended for Missouri Medicaid providers and billers if your Medicaid provider number begins with 40. The booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for entire content.

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Missouri Medicaid Dental Billing Book

Section 1: Medicaid Program Resources

Section 2: ADA 2000 Claim Filing Instructions

Section 3: Adjustments

Section 4: Prior Authorization

Section 5: Eligibility Restrictions

Section 6: Cost Sharing – Copay – Coinsurance

Section 7: Benefits & Limitations

Section 8: Dentures

Section 9: Orthodontics

Section 10: Custom-Made Items

Section 11: Resource Publications for Providers

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SECTION 1

MEDICAID PROGRAM RESOURCES

Informational Resources available at www.dss.mo.gov/dms

CONTACTING MEDICAID

PROVIDER COMMUNICATIONS

The following phone numbers are available for Medicaid providers to call the Provider Communications Unit with provider inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and recipient eligibility questions and verification. The toll free line provides an interactive voice response system that can answer questions regarding matters including recipient eligibility, last two check amounts, claim status and procedure code status. Providers must use a touchtone phone to access the system.

Provider Communications	800/392-0938
Interactive Voice Response (IVR)	800/392-0938
Standard Line	573/751-2896

The Provider Communications Unit also processes written inquiries. Written inquiries should be sent to:

Provider Communications Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

INFOCROSSING HEALTHCARE SERVICES, INC. HELP DESK **573/635-3559**

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Infocrossing Healthcare Services' Internet billing service.

PROVIDER ENROLLMENT

Providers can contact Provider Enrollment via email as follows for questions regarding enrollment applications: providerenrollment@mail.medicaid.state.mo.us

Changes regarding address, ownership, tax identification number, name (provider or practice), or Medicare number must be submitted in writing to:

Provider Enrollment Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY

573/751-2005

Call the Third Party Liability Unit to report injuries sustained by Medicaid recipients, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a Medicaid recipient.

PROVIDER EDUCATION

573/751-6683

Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for Medicaid claims. Contact the Unit for training information and scheduling.

RECIPIENT SERVICES

800/392-2161 or 573/751-6527

The Recipient Services Unit assists recipients regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MEDICAID EXCEPTIONS AND DRUG PRIOR AUTHORIZATION HOTLINE

800/392-8030

Providers can call this toll free number to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the Medicaid program, or to request a drug prior authorization. The Medicaid exceptions fax line for non-emergency requests only is 573/751-2439.

**HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT (HIPAA) INFORMATION**

Billing providers who want to exchange electronic information transactions with Missouri Medicaid can access the *HIPAA Companion Guide* online by going to the Division of Medical Services web page at www.dss.mo.gov/dms and clicking on the HIPAA Companion Guide link in the Quick Link box at the top of the page.

To access the *X12N Version 4010A1 Companion Guide*: 1) select Missouri Medicaid Electronic Billing Layout Manuals; 2) select System Manuals; 3) select Electronic Claims Layout Manuals; and, 4) select X12N Version 4010A1 Companion Guide.

For information on the Missouri Medicaid Trading Partner Agreement: 1) select Section 1 - Getting Started; and, 2) select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Infocrossing Healthcare Services, Inc., 573-635-3559.

INTERACTIVE VOICE RESPONSE (IVR)

800/392-0938

The Provider Communications Unit toll-free number, 800/392-0938 is answered by an Interactive Voice Response (IVR) unit which requires a touchtone phone. The nine digit Medicaid provider number **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

- Option 1 Recipient Eligibility
Recipient eligibility **must** be verified **each** time a recipient presents and should be verified **prior** to the service. Eligibility information can be obtained by a recipient's Medicaid number (DCN), social security number and date of birth, or if a newborn, using the mother's Medicaid number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.
- Option 2 Last Two Check Amounts
Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.
- Option 3 Claim Status
After entering the recipient's Medicaid number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).
- Option 4 Not currently in use.
- Option 5 Medicaid Information Messages
The caller will be given the option to select from several recorded messages providing the latest information regarding the Medicaid program.
- Option 6 Prior Authorization
This option allows pharmacy providers to verify the status of a prior authorization for an NDC (National Drug Code).

INTERNET SERVICES FOR MEDICAID PROVIDERS

The Division of Medical Services (DMS), in cooperation with Infocrossing Healthcare Services, has an Internet service for Missouri Medicaid providers. Missouri Medicaid providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify recipient eligibility;
- Obtain remittance advices (RAs);
- Submit Adjustments;
- Submit attachments; and
- View and download public files.

The web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the web site services. To participate in the service, the provider must apply on-line at <http://www.medicaid.state.mo.us/Application.html>. Each user is required to complete this on-line application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the www.emomed.com website. The password can be changed to one of the user's own choice.

Questions regarding the completion of the on-line Internet application should be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

This website, www.emomed.com, allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated:

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper web browser. The provider must have one of the following web browsers: Internet Explorer 5.0 or higher or Netscape 4.7 or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING RECIPIENT ELIGIBILITY THROUGH THE INTERNET

Providers can access Missouri Medicaid recipient eligibility files via the web site. Functions include eligibility verification by recipient ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MEDICAID CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- < 837 - Health Care Claim
 - Professional
 - Dental
 - Institutional (hospital inpatient and outpatient, nursing home, and home health care)
- < Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The Medicaid program phased out the mailing of paper Remittance Advices (RAs). Providers no longer will receive both paper and electronic RAs. If the provider or the provider's billing service currently receive an electronic RA, (either via the emomed.com Internet website or other method), paper copies of the RA were discontinued as of the July 20, 2004 financial cycle. All providers and billers must have Internet access to obtain the printable electronic RA via Infocrossing Healthcare Services' Internet service, emomed.com.

Receiving the Remittance Advice via the Internet is beneficial to the provider's or biller's operation. With the new Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks sooner than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider's or biller's operating system for retrieval at a later date.

The new Internet RA will be viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

To sign up for this service, see the instructions at the beginning of this information on Internet services. If a provider does not have access to the Internet, contact the Infocrossing Healthcare Services' Help Desk, (573)635-3559, to learn how to obtain a paper remittance.

ADJUSTMENTS THROUGH THE INTERNET

Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 – Replacement (Adjustment) or an 8 – Void (Credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the Adjustment Reason Codes and Remittance Advice Remark Codes.

MISSOURI MEDICAID PROVIDER MANUALS ON-LINE

www.dss.mo.gov/dms

How To Download/Print a Provider Manual

The following information assumes you are using a Microsoft Windows based operating system as your operating system. In order to be able to download and use all or a portion of an on-line Medicaid provider manual, you must have Adobe Acrobat Reader. If you already have this on your computer, you may disregard the first section and go directly to the sections detailing how to download and print the manuals.

NOTE: The provider manual information you download is current as of the time it is downloaded. Since periodic updates are made to the manuals, you must do a new download periodically so that your file will have the new or updated information.

A. Accessing and downloading Adobe Acrobat Reader program .

1. Open the DMS home page at www.dss.mo.gov/dms.
2. Scroll down, click on and open the line/link titled "Missouri Medicaid Provider Manuals".
3. In the newly opened page, scroll down and click on the yellow and red box at the bottom of the page titled "Get Acrobat Reader".
4. Once you have opened the Adobe Acrobat page, follow the instructions to download the free Adobe Acrobat Reader program to your computer system. Generally, the program will be installed in the C:/programs folder although you can put it in any folder you want.

B. Downloading and saving all or portions of a provider manual.

1. Go to the DMS home page at www.dss.mo.gov/dms.
2. Scroll down, click on and open the line/link titled "Missouri Medicaid Provider Manuals".
3. A new page will open. Click on the link titled "Missouri Medicaid Provider Manuals".
4. On the left side of the newly opened page, click on the "+" in front of the folder titled "Print A Manual" and click again on the subfolder. This opens a new frame in the upper right area of the screen titled "Print a Manual". In this frame scroll down to the provider manual you want to access and click on the manual to open to its contents page. Disregard the frame in the lower area of the page titled "Search Results".
5. When the page opens, it will display a number of links from which you can choose the one you want. The links allow you to access either the complete manual or sections of the selected manual.

For Internet Explorer Browser Users

For example, if you wish to download the entire physician's manual, place your pointer on the line/link titled "Complete Manual" and right click. A pop-up menu will appear. Click on the "Save Target As" button. Another pop window (Save As) will appear. Select where you want to save the file and its name. It can be saved either to a floppy disk or to a folder on the hard drive. If you rename the file, be sure to put the .pdf extension at the end of the new name. Click on the save button. The material then will be saved to the location/name you specified. Actual download time will vary depending on the file size of the information you want to download and the speed of your system's modem and your Internet service provider's system.

For Netscape Browser Users

For example, if you wish to download the entire physician's manual, place your pointer on the line/link titled "Complete Manual" and right click. A pop-up screen will appear. Click on "Save Link As". In the next pop-up window, select the drive/ folder where you want to save the data. You may rename file if you wish a name other than the name presented by the system. Add or change the file extension to .pdf (at the end of the file name), e.g. change phyman to phyman.pdf. Click save and the data will be saved to the location/name you specified. Actual download time will vary depending on the file size of the information you want to download and the speed of your system's modem and your Internet service provider's system.

Close the screens all the way back to the browser. Close the browser screen and return to your desktop.

C. Using Adobe Acrobat Reader to access the saved manual file.

1. Open Acrobat Reader either using the desktop icon or the program file.
2. Once the work screen is open, click on "File" in the taskbar.
3. On the task screen, select and click on "Open".
4. Select and highlight the drive location and name of your file. Acrobat Reader then will open your file.
5. You now have the option of viewing or printing all or portions of the file.

D. Printing all or portions of an opened Acrobat Reader Document

1. Click on "File" on the taskbar.
2. On the task screen, select and click on "Print" or "Print Target".
3. You have three options for printing from the file. All - prints the entire file
Current Page - prints only the page you have selected/highlighted. Pages
- gives you the option to print a specified range of consecutive pages.
4. When the print command has been sent to the printer, select "File" on the taskbar and "Exit" in the task screen to exit the program and return to your desktop.

CLAIM AND ATTACHMENT MAILING ADDRESSES

Medicaid paper claims and attachments related to claims must be sent to the following address as indicated.

Infocrossing Healthcare Services, Inc.
P.O. Box (see below for correct PO box number)
Jefferson City, MO 65102

P.O. Box 5100..... Inpatient Hospital Claims
P.O. Box 5200..... Outpatient Hospital Claims and RHC Claims
P.O. Box 5300..... Dental Claims
P.O. Box 5400..... Pharmacy Form Paper Claims
P.O. Box 5500..... Nursing Home Paper Claims
P.O. Box 5600..... DME, HCFA-1500, and Home Health Agency Claims
P.O. Box 5700..... Prior Authorization Requests
P.O. Box 5900..... Attachments forms including Second Surgical Opinion,
Acknowledgment of Receipt of Hysterectomy Information, SURS
Referral, Oxygen & Respiratory Equipment Medical Justification
and Certificate of Medical Necessity (DME providers only)

Infocrossing's physical address is: Infocrossing Healthcare Services, Inc.
905 Weathered Rock Road
Jefferson City, MO 65101

CLAIMS PROCESSING SCHEDULE FOR STATE FISCAL YEAR 2005

Cycle Run/Remittance Date* -

Friday, June 18, 2004
Friday, July 9, 2004
Friday, July 23, 2004
Friday, August 6, 2004
Friday, August 20, 2004
Friday, September 10, 2004
Friday, September 24, 2004
Friday, October 8, 2004
Friday, October 22, 2004
Friday, November 5, 2004
Friday, November 19, 2004
Friday, December 3, 2004
Friday, December 17, 2004
Friday, January 7, 2005
Friday, January 21, 2005
Friday, February 4, 2005
Friday, February 18, 2005
Friday, March 11, 2005
Friday, March 25, 2005
Friday, April 8, 2005
Friday, April 22, 2005
Friday, May 6, 2005
Friday, May 20, 2005
Friday, June 3, 2005

Check Date -

Tuesday, July 6, 2004
Tuesday, July 20, 2004
Thursday, August 5, 2004
Friday, August 20, 2004
Tuesday, September 7, 2004
Monday, September 20, 2004
Tuesday, October 5, 2004
Wednesday, October 20, 2004
Friday, November 5, 2004
Monday, November 22, 2004
Monday, December 6, 2004
Monday, December 20, 2004
Wednesday, January 5, 2005
Thursday, January 20, 2005
Monday, February 7, 2005
Monday, February 21, 2005
Monday, March 7, 2005
Monday, March 21, 2005
Tuesday, April 5, 2005
Wednesday, April 20, 2005
Thursday, May 5, 2005
Friday, May 20, 2005
Monday, June 6, 2005
Monday, June 20, 2005

*The Cycle Run Dates are tentative dates calculated by the Division of Medical Services. The dates are subject to change without prior notification.

*All claims submitted electronically to Infocrossing Healthcare Services must be received by 5:00 p.m. of the Cycle Run/Remittance Advice date in order to pay on the corresponding check date.

Holidays For State Fiscal Year 2005

July 5, 2004 Independence Day
September 6, 2004 Labor Day
October 11, 2004 Columbus Day
November 11, 2004 Veteran's Day
November 25, 2004 Thanksgiving
December 24, 2004 Christmas

December 31, 2004 New Years Day
January 17, 2005 Martin Luther King Day
February 11, 2005 Lincoln's Birthday
February 16, 2005 Washington's Birthday
May 9, 2005 Truman's Birthday
May 30, 2005 Memorial Day

SECTION 2

ADA 2000 CLAIM FILING INSTRUCTIONS

The ADA-2000 claim form should be typed or legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5300
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at www.dss.mo.gov/dms.

NOTE: An asterisk (*) beside a field number indicates a required field. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

<u>Field number and name</u>	<u>Instructions for completion</u>
1-7	Not required.
8.* Patient Name	Enter the patient's last name first, first name, and middle initial as shown on the patient's Medicaid card.
9. Address	Not required.
10. City	Not required.
11. State	Not required.
12. Date of Birth	Not required.
13*. Patient ID#	Enter the Medicaid ID number as shown on the patient's Missouri Medicaid card.
14. Sex	Not required.
15. Phone Number	Not required.
16. Zip Code	Not required.
17-18	Not required.

19-30**

When verifying the patient's eligibility, verify if there is other insurance coverage. If applicable, enter the name of the dental insurance, their address, and the policy number. If the other insurance pays, the amount paid should be entered in field 59, section "Payment By Other Plan".

LEAVE BLANK IF THERE IS NO OTHER DENTAL COVERAGE. (These fields should reflect only non-Medicaid information.)

31-37** Other Insurance

Required only if patient has a second dental policy. **LEAVE BLANK IF THERE IS NO OTHER DENTAL COVERAGE.** (This field should reflect only non-Medicaid information.)

38-41

Not required.

42.* Name of Billing Dentist
or Dental Entity

Write or type the provider's name exactly as it appears on the label.

43. Phone Number

Not required.

44.* Provider ID#

Write or type the provider's Missouri Medicaid number exactly as it appears on the provider label.

45. Dentist SSN or TIN

Not required.

46. Address

Not required.

47. Dentist License #

Not required.

48. First Visit Date

Not required.

49. Place of Treatment

Not required.

50. City

Not required.

51. State

Not required.

52. Zip Code

Not required.

**FIELDS 42, 46, 50, 51, AND 52 MAY BE COMPLETED WITH
THE USE OF THE MISSOURI MEDICAID PROVIDER LABEL.**

53.** Radiographs

Mark "yes" if x-rays accompany the claim. **Do not** send x-rays routinely, the State Dental Consultant will request them if needed. Refer to the Dental manual for specific procedures which require x-rays.

54-55.	Not required.
56.* Is Treatment a Result Of...	If treatment is the result of an occupational illness or injury, mark "yes" and list the date, location and cause, otherwise, mark "no".
57.* Is Treatment a Result Of...	Mark the appropriate box. If marked "yes", enter date and location.
58. Diagnosis Code Index	Not required.
59.* Date of Service	Enter the actual date services were rendered in month/day/year numeric format. REMINDER: The date of service for dentures (full or partial) is the date of placement.
* Tooth Number or Letter	<p>Enter the appropriate tooth number or letter for services performed on each line item of the claim. If a particular tooth number or letter does not apply, leave blank. When billing for partial dentures enter the tooth number for one of the teeth being replaced in this field, then list the remaining teeth in the description field.</p> <p> A – T Deciduous teeth 1 – 32 Permanent teeth AS – TS Deciduous supernumerary tooth 51 – 82 Permanent supernumerary tooth </p> <p>Alveoplasties should be billed using tooth number 1 for upper right quadrant, 9 for upper left quadrant, 17 for lower left quadrant, and 25 for lower right quadrant.</p>
* Surface Code	<p>Complete this field, if applicable.</p> <p> M – Mesial D – Distal O – Occlusal L – Lingual I – Incisal F – Facial B - Buccal </p>
Diagnosis Index #	Not required.

* Procedure Code	Enter the five digit code for the service performed, as well as any applicable modifiers.
* Quantity	The quantity will always be one (1) except for some injection codes.
** Description	Only required in specific situations as indicated in the Dental Manual.
* Fee	Enter your usual and customary fee for the procedure(s) performed.
* Total Fee	Enter the total of the charges shown.
**Payment by Other Plan	Enter the total amount received by all other insurance resources. Previous Medicaid payments, and cost-sharing, co-insurance, or copay amounts are not to be entered in this field. If the other insurance denied the claim, attach a copy of the Explanation of Benefits which denied the charges.
* Admin. Use Only	You may enter the recipient's patient account number in this field.
Maximum Allowable	Not required.
Deductible	Not required.
Carrier %	Not required.
Carrier Paid	Not required.
Patient Pays	Not required.
60. Identify the missing teeth...	Not required.
61.** Remarks	For timely filing purposes, if the claim is resubmitted after the date of service is one year old, enter the Internal Control Number (ICN) of the previous related claim, or attach a copy of the original remittance advice indicating the claim was initially submitted within one year from the date of service.
62-66	Not required.

Dental Claim Form

MISSOURI MEDICAID PROGRAM

©American Dental Association, 1999 version 2000

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services		3. Carrier Name			
2. <input type="checkbox"/> Medicaid Claim Prior Authorization # <input type="checkbox"/> EPSDT		4. Carrier Address			
		5. City		6. State 7. Zip	

PATIENT	8. Patient Name (Last, First, Middle)			9. Address			10. City			11. State		
	12. Date of Birth (MM/DD/YYYY) / /			13. Patient ID #			14. Sex <input type="checkbox"/> M <input type="checkbox"/> F			15. Phone Number ()		
	17. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			18. Employer/School Name _____ Address _____								

SUBSCRIBER / EMPLOYEE	19. Subs./Emp. ID#/SSN#			20. Employer Name			21. Group #			31. Is Patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes: <input type="checkbox"/> Dental or <input type="checkbox"/> Medical 32. Policy #		
	22. Subscriber/Employee Name (Last, First, Middle)											
	23. Address			24. Phone Number ()			34. Date of Birth (MM/DD/YYYY) / /			35. Sex <input type="checkbox"/> M <input type="checkbox"/> F		
	25. City			26. State			27. Zip Code			36. Plan/Program Name		
	28. Date of Birth (MM/DD/YYYY) / /			29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other			30. Sex <input type="checkbox"/> M <input type="checkbox"/> F			37. Employer/School Name _____ Address _____		

38. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student									40. Employer/School Name _____ Address _____		
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. X Signed (Patient/Guardian) _____ Date (MM/DD/YYYY) _____											
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X Signed (Employee/subscriber) _____ Date (MM/DD/YYYY) _____											

BILLING DENTIST	42. Name of Billing Dentist or Dental Entity			43. Phone Number ()			44. Provider ID #			45. Dentist Soc. Sec. or T.I.N.		
	46. Address			47. Dentist License #			48. First visit date of current series:			49. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other		
	50. City			51. State			52. Zip Code			53. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No		
	54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No			55. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No			56. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes			57. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither		
	58. If no, reason for replacement: _____			Date of prior placement: _____			Date appliances placed _____			Total mos. of treatment remaining _____		

58. Diagnosis Code Index (optional)													
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____													
59. Examination and treatment plans - List teeth in order													
Date (MM/DD/YYYY)		Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description				Fee	Admin. Use Only	
60. Identify all missing teeth with "X"													
Permanent								Primary					Total Fee
1 2 3 4 5 6 7 8								9 10 11 12 13 14 15 16					A B C D E F G H I J
32 31 30 29 28 27 26 25								24 23 22 21 20 19 18 17					T S R Q P O N M L K
61. Remarks for unusual services													
62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. X Signed (Treating Dentist) _____ License # _____ Date (MM/DD/YYYY) _____												63. Address where treatment was performed	
64. City _____ 65. State _____ 66. Zip Code _____													

©American Dental Association, 1999

GTE DATA SERVICES COPY

RETURN ORIGINAL TO:
GTE DATA SERVICES
P.O. BOX 5300
JEFFERSON CITY, MO 65102

SECTION 3 ADJUSTMENTS

Providers who are paid incorrectly for a claim should use the *Individual Adjustment Request* form to request an adjustment. For credits only, providers may also submit individual adjustments via the Internet. Adjustments may not be requested when the net difference in payment is less than \$4.00, or \$.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the \$4.00, or \$.25, minimum limitation does not apply.

In some instances, more than one change may be necessary on a claim. **All** the changes to the claim must be addressed on the same *Individual Adjustment Request* form. Specify all the changes required, addressing each change separately. Field 15 of the form may be used to provide additional information. More than one claim **cannot** be processed per *Individual Adjustment Request* form. Each adjustment request addresses one particular claim. A separate *Individual Adjustment Request* form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

If an adjustment does not appear on a Remittance Advice within 90 days of submission, a copy of the original *Individual Adjustment Request* and attachments should be resubmitted. Photocopies are acceptable. Mark this copy with the word "Tracer". Submitting another request without indicating it as a "tracer" can further delay processing. Adjustments for claim credits submitted via the Internet get a confirmation back the next day after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.

See Section 4 of the Medicaid *Provider Manual* for timely filing requirements for adjustments and claim resubmissions. *Individual Adjustment Request* forms are to be submitted to the address shown on the form.



Data Services

**MISSOURI MEDICAID
INDIVIDUAL ADJUSTMENT REQUEST**

☐ UNDERPAYMENT

☐ OVERPAYMENT

FORWARD TO:
ORIGINAL

DIV. OF MEDICAL SERVICES
ADJUSTMENT UNIT
P.O. BOX 6500
JEFFERSON CITY, MO 65102

TO FACILITATE PROCESSING,
PLEASE ATTACH THE FOLLOWING:

1. Claim Copy
2. Remittance Advice Copy

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE

3. INTERNAL CONTROL NUMBER

[illegible]

6. RECIPIENT NAME

4. RECIPIENT MEDICAID NUMBER

7. REMITTANCE ADVICE DATE _____

R.A. PAGE NUMBER _____

- ## 5. PROVIDER LABEL

REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS

		SERVICE DATE	INFORMATION ON REMITTANCE ADVICE	CORRECTED INFORMATION
8.	QTY/UNITS			
9.	NDC/PROCEDURE CODE			
10.	SERVICE DATE(S)			
11.	BILLED AMOUNT			
12.	PAID AMOUNT			
13.	PATIENT SURPLUS			
14.	OTHER RESOURCES (TPL) (IDENTIFY SOURCE)			
15.	OTHER/REMARKS			

16. PROVIDER'S
SIGNATURE _____ TITLE _____

DATE _____

SECTION 4

PRIOR AUTHORIZATION

Providers are required to seek prior authorization for certain specified services **before** delivery of the services. In addition to services that are available through the traditional Medicaid Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.

The following general guidelines pertain to all prior authorized services.

- A Prior Authorization (PA) Request (yellow form) must be completed and mailed to Infocrossing Healthcare Services, Inc, P.O. Box 5700, Jefferson City, MO, 65102. Providers should keep a copy of the original PA request form as the form is not returned to the provider.
- The provider performing the service must submit the PA request form. Sufficient documentation or information must be included with the request to determine the medical necessity of the service.
- PA requests are not to be submitted for services prescribed to an ineligible patient. State Consultants review for medical necessity only and do not verify a patient's eligibility.
- Expanded HCY (EPSDT) services are limited to patients under the age of 21 and are **not** reimbursed for patients 21 and over even if prior authorized.
- Payment is **not** made for services initiated before the approval date on the PA request form or after the authorization deadline. For services to continue after the expiration date of an existing PA, a new PA request **must** be completed and mailed to Infocrossing Healthcare Services.
- An approved prior authorization **does not** guarantee payment.

Whether the prior authorization is approved or denied, a disposition letter will be mailed to the provider containing all of the detail information related to the prior authorization request. All other documentation submitted with the prior authorization request will not be returned. All requests for changes to an approved prior authorization should be indicated on the disposition letter and submitted to the same address as the original prior authorization request. PA requests which are denied must be resubmitted to Infocrossing with additional documentation as needed. Providers do not have to obtain a new PA request form but may submit a legible copy of the original PA request.

Instructions for completing the PA request form are found in Section 8 of the Medicaid *Provider's Manual* available on the Internet at www.dss.mo.gov/dms. Instructions are also self-contained on the back of the PA request form.



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1.	2. NAME (LAST, FIRST, M.I.)	3. DATE OF BIRTH
4. ADDRESS (STREET, CITY, STATE, ZIP CODE)		5. MEDICAID NUMBER
6. PROGNOSIS	7. DIAGNOSIS CODE	8. DIAGNOSIS DESCRIPTION
9. NAME & ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE.		

II. HCY (EPSDT) SERVICE REQUEST

(MAY REQUIRE PLAN OF CARE)

10. DATE OF HCY SCREEN	11. SCREENING <input type="checkbox"/> FULL <input type="checkbox"/> INTERPERIODIC <input type="checkbox"/> PARTIAL	12. TYPE OF PARTIAL HCY SCREEN
13. SCREENING PROVIDER NAME	14. PROVIDER NUMBER	15. TELEPHONE NUMBER

III. SERVICE INFORMATION

(DO NOT WRITE IN SHADED AREAS)

FOR STATE USE ONLY

16. REF. NO.	17. TYPE SERV.	18. PROCEDURE CODE	19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE/ITEM	22. QTY. OR UNITS	23. AMOUNT TO BE CHARGED	APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
(11)										
(12)										

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

25. PROVIDER NAME (AFFIX LABEL HERE)
26. ADDRESS
27. MEDICAID PROVIDER NUMBER
28. SIGNATURE
DATE

V. PRESCRIBING/PERFORMING PRACTITIONER

29. NAME	30. TELEPHONE
31. ADDRESS	
32. DATE DISABILITY BEGAN	33. PERIOD OF MEDICAL NEED IN MONTHS
I certify that the information given in Sections I and III of this form is true, accurate, and complete.	
34. SIGNATURE OF PRESCRIBING PHYSICIAN/PRACTITIONER	DATE

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin	DATE	REVIEWED BY SIGNATURE ►
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INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION – To be completed by the provider requesting the prior authorization.

1. Leave Blank
2. Recipients Name – Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipients current address.
3. Date of Birth – Enter the recipient's date of birth.
4. Address – Enter the recipients address, city, state, and zip.
5. Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis – Enter the recipients prognosis.
7. Diagnosis Code – Enter the diagnosis code(s).
8. Diagnosis Description – Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen – Enter the date the HCY Screen was done.
11. Screening -Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen – Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name – Enter the provider's name who performed the screening.
14. Provider Number – Enter the provider's number who performed the screening.
15. Telephone Number – Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. = (Reference Number) A unique designator (1-12) identifying each separate line on the request.
17. Type of Service – Enter the appropriate type of service code for each procedure code.
18. Procedure Code – Enter the procedure code(s) for the services being requested.
19. From – Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through – Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item – Enter a specific description of the service/item being requested.
22. Quantity or Units – Enter the quantity or units of service/item being requested.
23. Amount to be Charged – Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/prosthesis, etc. Attach additional page(s) as necessary.
Do not use another Prior Authorization Form.

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid Identification number.
28. Signature/Date -The provider of services should sign the request and indicate the date the form was completed.
(Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name – Enter the name of the prescribing/performing/practitioner.
30. Telephone Number – Enter the prescribing/performing/practitioner telephone number including area code.
31. Address – Enter the address, city, state, and zip code.
32. Date Disability Began – Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months – Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner-The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 12). The consultant will sign or initial the form.

SECTION 5

ELIGIBILITY RESTRICTIONS

A patient must be eligible for Medicaid on each date a service is provided in order for a provider to receive Medicaid payment for those services. This is also a requirement even when the service has been prior authorized. It is the provider's responsibility to verify a patient's Medicaid eligibility. The following ME (medical eligibility) codes have restricted dental benefits:

09-GR (General Relief): Restricted coverage for patients 21 and over, treatment of trauma and disease, non-periodontal. Benefits for patients under the age of 21 are covered to the same extent they are for all Medicaid eligible patients.

55-QMB (Qualified Medicare Beneficiary): A mandatory coverage group under Medicaid providing payment for qualified individuals of deductible and coinsurance amounts for ***Medicare covered services***.

58 & 59-Presumptive Eligibility (TEMP): Coverage is limited to ambulatory prenatal care services only.

76-Transitional Parents (uninsured): Restricted coverage for treatment of trauma and disease, non-periodontal.

80-Services For Women Following The End Of Pregnancy: Coverage is limited to family planning, and testing and treatment of sexually transmitted diseases (STD's).

Additional information regarding the limitations and restrictions for the above categories of assistance can be found in Sections 1 and 13 of the Medicaid *Provider's Manual* available on the Internet at www.dss.mo.gov/dms.

SECTION 6

COST SHARING – COPAY – COINSURANCE

Providers of service must charge and collect the cost sharing, copay or coinsurance amount from patients, unless otherwise exempt. It is the responsibility of the patient to pay the required amount due. Providers may not deny or reduce services to patients, otherwise eligible for benefits, solely on the basis of the patient's inability to pay. Whether or not the patient is able to pay the required amount at the time the service is rendered, the amount is a legal debt and is due and payable to the provider of service.

Cost Sharing

The following cost sharing amounts are applied to *dental* services; CPT or surgical procedures are not subject to cost sharing. The amount of cost sharing to be collected from the patient is based on the Missouri Medicaid Maximum Allowed Amount *per* procedure.

<u>Medicaid Maximum Allowable</u>	<u>Cost Sharing</u>
\$10.99 or less	\$.50
\$11.00 - \$25.99	\$ 1.00
\$26.00 - \$50.99	\$ 2.00
\$51.00 or more	\$ 3.00

Exemptions to Cost Sharing & Coinsurance

- Patients age 17 and under
- Foster Care children up to 21 years of age, ME codes 07 and 08
- Hospice patients
- Patients residing in skilled nursing facilities
- Patients residing in residential care facilities or adult boarding homes with ME codes 14, 15, or 16
- MC+ health care plan enrollees for services provided by the health plan
- When copay is charged for patients with ME codes 74, 75 and 76
- When coinsurance is charged for dentures

Copay

Patients with ME code 74 must pay a \$5.00 copay for identified services; patients with ME codes 75 and 76 must pay a \$10.00 copay. These copay amounts apply whether the patient receives services on a fee-for-service basis or is enrolled in a health plan. The following services require copay:

99201	99211	D0120	D9310
99202	99212	D0140	D9430
99203	99213	D0150	D9440
99204	99214	D0160	
99205	99215	D0170	

Denture Coinsurance

The coinsurance amount applies to each interim, partial and full denture unless the patient meets one of the above exemptions. The amount collected from the patient is 5% of the lesser of Medicaid's maximum allowable amount or the provider's billed charge.

<u>Procedure Code</u>	<u>Medicaid Maximum Allowable</u>
D5110	\$ 357.00
D5120	\$ 355.00
D5130	\$ 361.00
D5140	\$ 360.00
D5211	\$ 272.00
D5212	\$ 276.00
D5213	\$ 385.00
D5214	\$ 386.00
D5820	\$ 286.00
D5821	\$ 286.00
D5860	\$ 457.50
D5861	\$ 457.00

NOTE: Procedure codes D5860 and D5861 require an approved prior authorization and are restricted to patients under the age of 21.

SECTION 7 BENEFITS & LIMITATIONS

Office Visit Limitations

An office visit includes, but is not limited to, the following:

- Oral examination of the patient for symptoms or indications of a dental condition requiring treatment;
- Establishment of the written patient record;
- Surgical gloves, drapes, tongue depressors, swabs, gauze, medications, administration of injection(s) and any other items or supplies considered to be routine to the dentist's private practice; and
- Local anesthesia.

Office visits are limited to one visit per patient per provider on any given day and may not be billed on the same date of service as another office or outpatient visit, dental screen, subsequent hospital visit, consultation or nursing home visit. An office visit may be billed on the same date of service as a hospital admission.

Procedure codes 99201-99332 cannot be billed on the same date of service as procedure codes D0120-D0170 and D9310-D9440.

"New Patient" office visits are limited to one per provider for each patient when dental services have not been received in the past two years.

Billing for an office visit is expected *only* for the first session in a series of treatments.

Providers cannot bill a patient for missed/broken appointments, nor can the Division of Medical Services (DMS) reimburse providers for missed/broken appointments.

Preventative

Prophylaxis of either the upper or lower arch or both arches is covered once in a six-month period. ***If a prophylaxis is required more often than every six months, a provider may bill under procedure code D9999 and attach office notes to the claim form explaining the medical necessity.*** Prophylaxis must include scaling and polishing of teeth unless scaling is not required for the individual (usually a child) based on the condition at the time of the appointment. The patient's record must document scaling was not required during the visit.

D1110 – Ages 13-125

D1120 – Ages 0-12

Fluoride treatment is limited to one application of stannous fluoride or acid-phosphate fluoride in six-month intervals. Each allowable fluoride treatment must include both the upper and lower arch. Fluoride treatments are covered for patients under the age of 21.

D1201 – Includes the prophylaxis

D1203 – Prophylaxis not included

Fluoride treatments for patients 21 and over (D1204) are limited to the following criteria:

- Patients with rampant or severe caries (decay);
- Patients who are undergoing radiation therapy to the head and neck;
- Patients with diminished salivary flow;
- Mentally retarded individuals who cannot perform their own hygiene maintenance; or
- Patients with cemental or root surface caries secondary to gingival recession.

Sodium fluoride series treatments are *not* covered.

Dental sealants are covered for patients age 5 through 20, with the exception of patients with ME code 76. Sealants may be applied only on healthy first and second permanent molars which have not had the occlusal surface restored. Valid tooth numbers are 2, 3, 14, 15, 18, 19, 30 and 31. Payment for each tooth is a once in a lifetime fee. No payment is made for sealants applied to third molars.

Periodontal Scaling and Root Planing – D4341

Procedure code D4341 requires an approved prior authorization (PA). Along with the PA request, providers must submit a pretreatment x-ray (a full mouth survey taken within the last 12 months) and a periodontal chart. The following guidelines are used to determine medical necessity for approval of the PA request. Approval, if given, is per quadrant:

- Verifiable signs of early or moderate chronic periodontia;
- Records must show two or more sites in the quadrant being treated with;
 - 1) probing depths of 5mm or greater; **and**
 - 2) early to moderate bone loss, **or**
 - 3) radiographic evidence of subgingival calculus.

Definition of bone loss:

- Early bone loss is cratering, or horizontal or vertical loss.
- Moderate bone loss is notable bone loss with 50% of the root remaining in the bone.

Restorations

- ❑ The same restoration on the same tooth in less than a six-month period is not allowed.
- ❑ Amalgam restorations include polishing, local anesthesia, liner and treatment base.
- ❑ Resin restorations include local anesthesia, liner and treatment base.
- ❑ When billing for any of the amalgam, composite or resin restorations, the tooth number and tooth surface code(s) must be entered on the claim.
- ❑ Amalgam and resin restorations on posterior teeth are covered; resin restorations are covered on *anterior* teeth.

Crowns

- ❑ Prefabricated stainless steel crowns (D2930 and D2931) and prefabricated stainless steel crowns with resin window (D2933) for primary and permanent teeth are covered for patients of all ages; replacement within six months is not covered.
- ❑ Prefabricated resin crowns are covered for patients of all ages for *anterior* teeth only; replacement within six months is not covered.
- ❑ The fee for fixed prefabricated crown of chrome, stainless steel, resin, stainless steel with resin window or polycarbonate includes all prior preparations.
- ❑ Temporary crowns, D2970, are covered for patients under the age of 21.
- ❑ Porcelain crowns are covered for patients under the age of 21 on a prior authorized basis.

Extractions

- ❑ Procedure code D7140 is the appropriate code for all non-surgical extractions of erupted teeth, permanent and primary. The appropriate tooth number must be shown on the claim.
- ❑ Surgical removal of erupted teeth, D7210, is covered for permanent teeth only.
- ❑ The surgical removal of impacted teeth, D7220-D7241, is a covered service. A paper claim must be submitted for the removal of impacted teeth other than third molars and must include pre-treatment x-rays.
- ❑ The surgical removal of residual tooth roots (cutting procedure), D2750, is covered but cannot be billed on the same date of service as an extraction of the same tooth. Pre-treatment x-rays and office notes or operative report must be sent with the claim.
- ❑ Extraction fees for routine and impacted teeth include the fee for local anesthesia and post-operative treatment.

Please refer to Section 13 of the Medicaid *Dental Provider's Manual* and the Dental Appendix for comprehensive coverage of dental benefits and limitations, as well as covered procedure codes, available on the Internet at www.dss.mo.gov/dms.

SECTION 8 DENTURES

Dentures must be dispensed to the patient before the provider bills Medicaid; the date of service for dentures is the date of placement. Holding dentures until Medicaid payment is received constitutes payment for services not provided and is in violation of State Regulation 13 CSR 70-3.030(2)(A)23. Providers may not request or accept a deposit from a Medicaid patient and then refund it after payment is received from Medicaid. Accepting a deposit or a portion of the fee or charge is in violation of State Regulation 13 CSR 70-3.030(2)(A)9. *This does not apply to the denture coinsurance requirement.* Medicaid reimbursement for dentures include routine visits necessary in the steps required for the denture, full or partial. This includes impressions, try-ins and adjustments for six months from the date of placement.

Prior authorization is not required for full (D5110-D5140), partial (D5211-D5214) or interim (D5820-D5821) dentures. Prior authorization is required for overdentures (D5860 & D5861), however, coverage is restricted to patients under the age of 21, with the exception of patients with ME code 76.

Immediate and interim dentures are restricted to once in a lifetime.

Replacement dentures are covered in cases when dentures no longer fit properly due to:

- significant weight loss as a result of illness;
- loss of bone or tissue due to some form of neoplasm and/or surgical procedure;
- normal wear and/or deterioration resulting from use over an extended period of time.

NOTE: Replacement dentures do not require prior authorization; PA requests submitted to Infocrossing will not be approved. Dentists must use their professional judgment in determining if their patient's denture meets the above replacement criteria. The reason for replacing the patient's denture must be properly documented in the patient's record.

Denture adjustments are covered, but not for the originating dentist of a new denture until six months from the date of placement. It is the responsibility of the dentist who placed the denture to assure correct fit within this period.

Rebases and Relines

One reline or rebase is allowed *during* the 12 months following placement of *immediate* dentures. The second reline or rebase is allowed 12 months following the first reline. Additional denture relining or rebasing is limited to 36 months from the date of the preceding reline or rebase.

The initial reline or rebase of a partial or replacement denture is not covered until 12 months after the placement of the denture. Additional relining or rebasing is limited to 36 months from the date of the last preceding reline or rebase.

Denture reline or rebase, where necessary, may be accomplished on the same date of service as repair of a broken denture.

Rebasing of any denture, full or partial, must include a new impression of the old denture, check bite, and full-process procedure.

Laboratory reline of any denture, full or partial, must include a new impression of the old denture, check bite, and full-process procedure.

Tissue conditioning, D5820 and D5821, is not covered for the same date of service as a reline and/or rebase.

SECTION 9 ORTHODONTICS

Orthodontic procedures are covered as expanded HCY, Healthy Children and Youth, services. Medically necessary orthodontics is available to all Medicaid eligible patients under the age of 21 with the exception of those patients with ME code 76. These services do require prior authorization (PA) and are only approved for the most handicapping malocclusions. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables:

- Degree of mal-alignment
- Missing teeth
- Angle classification
- Overjet
- Overbite
- Openbite
- Crossbite

Comprehensive orthodontic treatment is available only for transitional mixed (dentition) or full adult dentition. Exceptions to this policy are granted only in cases of cleft palate or severe facial anomalies where early intervention is in the best interest of the patient. Comprehensive orthodontic treatment includes, but is not limited to:

- Complete diagnostic records and a written treatment plan;
- Placement of all necessary appliances to properly treat the patient (both removable and fixed appliances);
- Removal of all appliances at the completion of the active phase of treatment;
- Placement of retainers or necessary retention techniques;
- Adjustment of the retainers and observation of the patient for a proper period of time (approximately 18-24 months).

Extractions are not included in the fee for the orthodontic treatment but are separately covered under the Dental Program.

Requests for orthodontic treatment are assessed by using the Handicapping Labio-Lingual Deviation (HLD) Index. When submitting a PA request, the provider must include complete orthodontic records and a written treatment plan. Providers must label the orthodontic records, which must include at a minimum, the provider's name or number and the patient's Medicaid/MC+ ID number. If the models and/or x-rays are unusable, they are rejected and new records must be submitted prior to authorization of treatment. The PA request, along with the required records and treatment plan, must be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5700
Jefferson City, MO 65102

Upon receipt of an approved PA, the provider must verify the patient's Medicaid eligibility prior to beginning orthodontic treatment. It is important the patient's eligibility be verified each time a treatment/service is rendered. The approved PA will state the length of treatment authorized, i.e., 24 months, as well as the total dollar amount authorized for the duration of the treatment.

Payment for the initial phase of a comprehensive orthodontic treatment program may occur after the initial banding has been completed. The initial fee is based on one-fourth of the total approved amount. This fee includes the orthodontic examination, preparation of the necessary dental records, determining the diagnosis, a written treatment plan and placement of appliances. The date of service for the initial payment is the date of banding.

Providers must bill subsequent payments on a quarterly basis. The amount of the quarterly payment is determined by the balance due after the initial payment has been deducted from the prior authorized amount. The remainder is divided by the total number of months treatment was authorized, and the result multiplied by three. This dollar amount represents the amount of all future quarterly payments with the date of service being the last day of the month of each quarter following banding.

Example:

Provider is authorized \$2,000.00 for a 24-month treatment plan. The patient is banded on October 26, 2003. The initial claim will be submitted with a date of service of 10/26/03 and a dollar amount of \$500.00. To determine the date of the first quarterly payment, the month the patient was banded is counted as month one, therefore, the date of service for the first quarterly payment in this example is 12/31/03. The quarterly payment amount to be billed is \$187.50: $\$1,500.00 \div 24 = \62.50 ; $\$62.50 \times 3 = \187.50 . The date of service for the second quarterly payment is 03/31/04; the third, 06/30/04; the fourth, 09/30/04, etc. The quarterly payment billed remains the same.

If a patient is only eligible for one or two months of the quarter, the provider must bill the exact dates the patient was seen in the office. Each month must be billed on a separate line and the allowed amount for each month is one-third of the quarterly payment.

If the patient's eligibility ends prior to the last day of the quarter, but after the patient is seen in the third month of the quarter, the last date of eligibility during the third month of the quarter is the date of service.

SECTION 10

CUSTOM-MADE ITEMS

Medicaid provider payment may be made for custom-made items such as dentures when a patient becomes ineligible (either through complete loss of Medicaid eligibility or change of assistance category to one for which the particular service is not covered) or dies after the item is ordered or fabricated and prior to the date of delivery or placement of the item.

The following prerequisites apply to all such payments:

- ❑ The patient must have been eligible when the service was first initiated (and following receipt of an approved PA request form if required) and at the time of any subsequent service, preparatory and prior to the actual ordering or fabrication of the device or item;
- ❑ The custom-made device or item must have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for a medical purpose by any other individual;
- ❑ The custom-made device or item must have been delivered or placed if the patient is living;
- ❑ The provider must have entered "See Attachment" in the "Remarks" section of the dental claim form (field #61) and must have attached a provider signed statement to the claim. The statement must explain the circumstances and explain the circumstances and include the date of actual delivery or placement for a living patient or the date of death when delivery or placement is not possible due to this reason. The statement must also include the total amount of salvage value, if any, which the provider estimates is represented in cases where delivery or placement is not possible.

Payments regarding the aforementioned devices are made as follows:

- a. If the item is received by the patient following loss of Medicaid eligibility or eligibility for the service, the payment is the lesser of the billed charge or the Medicaid maximum allowable for the total service, less any applicable coinsurance and any payments made by another insurance.
- b. If the item cannot be delivered or placed due to death of the patient, the payment is the lesser of the "net billed charge" or the Medicaid maximum allowable for the total service, less any applicable coinsurance. The "net billed charge" is the provider's usual and customary billed charge(s) as reduced by any salvage value amount.

Salvage value exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item.

Dentures are an example of an item representing no reasonable salvage value.

The date of service that is shown on the claim form for the item (dentures) when situation a) or b) applies must be the last date on which service is provided to the eligible patient (and following receipt of an approved PA request if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying patient eligibility each time a service is provided. Use of a date for which the patient is no longer eligible for Medicaid coverage of the service results in a denial of the claim. The claim (with attachment) is to be submitted to the fiscal agent (currently Infocrossing Healthcare Services, Inc.) in the same manner as other claims.

Payments made as described in a) or b) constitute the allowable Medicaid payment for the service. Other than any applicable coinsurance due, no further collection from the patient or other persons is permitted.

If the provider determines the patient has lost eligibility after the service is first initiated and before the custom-made item is actually ordered or fabricated, the patient must be immediately advised that completion of the work and delivery or placement of the item is not covered by Medicaid. It is then the patient's choice whether to request completion of the work on a private payment basis. If the patient's death is the reason for loss of eligibility, the provider can, of course, proceed no further and there is no claim for the non-provided item of service.

If a patient refuses to accept the item/service, Missouri Medicaid does not reimburse the provider.

SECTION 11 RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT DENTAL TERMINOLOGY, FOURTH EDITION (CDT-4)

Missouri Medicaid currently uses the *Current Dental Terminology, fourth edition (CDT-4)*. This publication is a series of dental procedure codes used for reporting services rendered. All providers should obtain and refer to the CDT-4 to assure proper coding.

CURRENT PROCEDURE TERMINOLOGY (CPT)

Missouri Medicaid also uses the latest version of the *Current Procedural Terminology (CPT)*. All providers are encouraged to obtain and refer to the CPT book to assure proper coding.

Providers can order CDT and/or CPT books from the following:

Practice Management Information Corporation
4727 Wilshire Blvd., Ste. 300
Los Angeles, CA 90010
1-800-663-7467
<http://pmiconline.com>

Medical Management Institute Campus Bookstore
11405 Old Roswell Road
Alpharetta, GA 30004
1-800-334-5724 ext. 1
<http://www.codingbooks.com>

SECTION 12

RECIPIENT LIABILITY

State Regulation 13CSR 70-4.030

If an enrolled Medicaid provider does not want to accept Missouri Medicaid as payment but instead wants the patient (recipient) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that Medicaid will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to Medicaid for reimbursement for the covered service(s).

If Medicaid denies payment for a service because all policies, rules and regulations of the Missouri Medicaid program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before Medicaid is billed.

MEDICAID RECIPIENT REIMBURSEMENT (MMR)

The Medicaid Recipient Reimbursement program (MMR) is devised to make payment to those recipients whose eligibility for Medicaid benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Recipients are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The recipient is furnished with special forms to have completed by the provider(s) of service. If Medicaid recipients have any questions, they should call (800) 392-2161.

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

Or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.



Director, Department of Social Services

2004
Year